Vision of HIPAA

- Single set of information for all payers
- Standard, easily understood coding rules
- Standard responses from payers
- Little, if any human intervention for billing, remittance, posting, eligibility inquiries, coordination of benefits
- Secure data, well understood privacy protection
Vision of HIPAA

- Additional patient medical records information easily (and securely) exchanged between
- Entities easily and clearly identified in transactions

- How have we done?
Brief History

- Law – 1996
- Final Rules
  - Transactions – 2000 (finally effective October 2003)
  - Privacy – 2000 (effective April 2003)
  - Employer ID – 2002
  - Transactions Modifications – 2003
  - Security – 2003
  - National Provider ID -2004
Transactions Status

- Effective Oct 16 2003 (after ASCA extension)
- CMS Contingency Plan Guidance allows for transition period to keep funds flowing
- However, entities should be compliant
Transactions Status

- Enforcement in Place
  - Complaint based
  - Aim is to get to compliance
  - Will look at good faith efforts
  - Web site available
Complaint statistics

- 106 Transaction/Code Set Complaints
  - 45 closed
  - 61 open
- Most regarding claim
- Adverse impact to cash flow
- Small providers against health plans and clearinghouse.
- 5 corrective action plans submitted
Where is the Industry Today?

- Lots of contingency plans, but
  - Many moving into compliance
  - Medicare rate above 80% for claims

- Why not compliant?
  - New data elements
  - Reliance on vendors
  - Not enough time for testing – started implementation too late
What Will/Should be Happening?

- Contingency plans will end
- Entities must be compliant, or payments may stop
- Need to embrace other transactions – automated eligibility, remittance, claims status
- Need to participate in standards revision process
Some Positive Impacts

- Realization that standards impact business process
- Industry getting together to implement
- Different provider groups coming forward to participate in standards
Next Standard to Implement

- Security!
Regulation Dates

- Published February 20, 2003
- Effective Date April 21, 2003

- Compliance Date:
  - April 21, 2005 for all covered entities except small health plans
  - April 21, 2006 for small health plans (as HIPAA requires)
General Requirements (164.306(a))

- Ensure
  - Confidentiality (only the right people see it)
  - Integrity (the information is what it is supposed to be – it hasn’t been changed)
  - Availability (the right people can see it when needed)
General Requirements

- Applies to Electronic Protected Health Information
- That a Covered Entity Creates, Receives, Maintains, or Transmits
General Requirements

- Protect against reasonably anticipated threats or hazards to the security or integrity of information
- Protect against reasonably anticipated uses and disclosures not permitted by privacy rules
- Ensure compliance by workforce
Regulation Themes

- Scalability/Flexibility

  - Covered entities can take into account:
    - Size
    - Complexity
    - Capabilities
    - Technical Infrastructure
    - Cost of procedures to comply
    - Potential security risks
Regulation Themes

- Technologically Neutral
  - What needs to be done, not how

- Comprehensive
  - Not just technical aspects, but behavioral as well
How Did We Accomplish This

- Standards Are Required but:
  - Implementation specifications which provide more detail can be either required or addressable.
Addressability

- If an implementation specification is addressable, a covered entity can:
  - Implement, if reasonable and appropriate
  - Implement an equivalent measure, if reasonable and appropriate
  - Not implement it
- Based on sound, documented reasoning from a risk analysis
Chart in Regulation

- At end of the regulation, this chart lists each standard, its associated implementation specifications, and if they are required or addressable
Implementation Approach

- Do Risk Analysis – Document
- Based on Analysis, determine how to implement each standard and implementation specification – Document
- Train Workforce
- Implement Policies and Procedures
- Periodic Evaluation
Summary

- Scalable, flexible approach
- Standards that make good business sense
- Two years for implementation
- First step is risk analysis
CMS and Other Resources

- CMS HIPAA Web Site – www.cms.hhs.gov/hipaa/hipaa2
  - FAQs
  - Guidance Documents
  - AskHIPAA@cms.hhs.gov email box
  - Teleconferences
Other Resources

- NIST – Crosswalk document published for public comment
- WEDI/SNIP – Security white papers
Then, NPI
National Provider Identifier

- Final Rule Published January 23rd
- Adopt the standard for a single identifier for every provider
- No need for different identifiers for different health plans
NPI: Important Dates

- Final Rule published on January 23, 2004
- Effective date is May 23, 2005

Providers can begin applying for NPIs

- Compliance dates are:
  - **May 23, 2007** for all covered entities except small health plans
  - **May 23, 2008** for small health plans

By these dates, covered entities must use NPIs to identify providers in standard transactions.
NPI: What it will and will not do

- It will:
  - Replace the use of legacy provider identifiers (e.g., UPIN, Medicaid Provider Number, Medicare Provider Number, Blue Cross and Blue Shield Numbers) in standard transactions as of the compliance dates
  - Simplify transactions, including claims and COB, and save money in the long term

- It will not:
  - Guarantee reimbursement by health plans
  - Enroll providers in health plans
  - Make providers covered entities
  - Require providers to conduct electronic transactions
  - Serve the purposes of the DEA or taxpayer numbers
NPI: What does it look like?

- 10 positions (9 plus the check-digit)
- All numeric
- Does not convey information about the provider
- Is compatible with health insurance card issuer standard
NPI: Who can have an NPI?

- Any “health care provider” (160.103)
  - Both covered and noncovered providers
  - Individuals: Physicians, dentists, nurses, chiropractors, others
  - Organizations: Hospitals, ambulatory care facilities, laboratories, HMOs, group practices, others
- Subparts of Organization providers
NPI: What is a “subpart”? 

- A covered health care provider is a legal entity 
- Subpart is *not* a legal entity but is part of the covered provider and it furnishes health care 
- Examples: Hospital unit, member of chain 
- A subpart does not necessarily correlate to “health care component” or “organized health care arrangement” 
- Concept does not apply to individuals
NPI: Covered providers and “subparts”

- Covered provider responsible for determining subpart’s need for NPI
- If need exists, covered provider responsible for subpart obtaining NPI
- Covered provider responsible for enumerated subpart’s compliance with Final Rule
NPI: How does a provider obtain one?

- Provider completes application form to apply for NPI
  - Can file electronically or on paper
  - Application is processed by NPS
    -- Data editing
    -- Data validation
    -- Duplicate detection
- Provider receives notification of NPI
NPI: Ensuring unique identification of a provider

- Information collected on application for NPI used for assignment of NPI
- Minimum information necessary for unique identification and communication
- Different information for individuals and organizations
- Data elements are categorized as:
  - Required or
  - Situational or
  - Optional
NPI: The National Provider System (NPS)

- Developed under contract with HHS
- Will process NPI applications and assign NPIs
- Will store information about enumerated providers and apply providers’ updates
- Will generate reports and statistics
- System of Records Notice (July 28, 1998)
NPI: The enumerator

- Will operate under HHS contract
- Will receive applications and updates
- Will resolve errors, help with problems, and answer questions
- Will handle data requests
- Will operate the NPS
NPI: Enumerating existing providers

- Providers do not have to take any action at this time
- May 23, 2005: Providers may begin applying for NPIs
  - Extremely heavy initial demand
  - Covered providers *must* begin using NPIs in standard transactions within 2 years (by May 23, 2007)
NPI: Enumerating existing providers (cont.)

- Noncovered providers may apply for NPIs
  - Being assigned NPIs does not make them covered entities
  - There is no statutory or regulatory requirement for them to obtain or use NPIs
  - We encourage them to obtain and use NPIs
  - Health plans are not prohibited from requiring enrolled providers who are not covered providers to obtain and use NPIs if they are eligible for NPIs
NPI: Disseminating data

- 3 levels of users
  - 1-HHS/enumerator
  - 2-Health industry
  - 3-The public
- NPS System of Records Notice
  - Required uses, users of NPS data
- Protect confidentiality of data
- Heavy initial demand for data
- Strategy to be published
NPI: Requirements - Covered Providers

- Obtain an NPI for itself (and subparts if appropriate)
- Use its NPI to identify itself in standard transactions
- Disclose its NPI when requested
- Furnish updates to NPS (30 days)
- Require BAs to use all NPIS appropriately
- Comply with requirements for subpart(s)
NPI: Requirements – Health plans and clearinghouses

- Must use NPIs to identify providers in standard transactions
- Health plans may not require enumerated providers to obtain additional NPIs
NPI: What should covered entities be doing now?

- Become informed about the NPI and its implementation
- Educate staff
- Identify processes/systems that are affected by provider identifiers
- Develop implementation plans (internal, external with trading partners and others)
NPI: Effect on providers

- No longer necessary to use different identifiers in standard transactions for different health plans, contract arrangements, locations
- Simplifies billing
- Speeds up COB payments
NPI: Effect on health plans

- One number per provider/subpart
- A covered provider will use only its NPI to identify itself in standard transactions
- A noncovered provider with an NPI will use only its NPI to identify itself in standard transactions
NPI: Its effect on health plans (cont.)

- May discontinue use/maintenance of existing provider enumeration systems
- NPI does not reveal anything about the provider
- Simplifies COB
- Facilitates UR and PI
NPI: Its effect on health plans (cont.)

- Identify systems and processes that use provider identification numbers in order to replace with/link to NPIs
- Assess impact on data integrity
- Assess need for crosswalks
NPI: Its effect on health plans (cont.)

- Must continue to conduct provider enrollment processes, to include collecting and validating data not in the NPS:
  - Education, licensing, certification
  - Group memberships
  - Multiple practice location addresses
- Coordinate implementation date with providers, other trading partners
NPI: Effect on health care clearinghouses

- Similar to effects on health plans
- Operations involve many providers and many health plans
- May have to accommodate identifiers of noncovered providers who do not obtain NPIs
- Coordinate implementation date with trading partners
NPI: Effect on X12N IGs

- NPI used as the provider’s Primary--and only--Identifier

- Legacy identifiers (Secondary Identifiers) will not be used after 5/23/07 to identify providers who have NPIs

- EIN (issued by IRS) may be used, for tax purposes, per the IGs (Pay-to, Billing Providers)

- FR does not require NPI to replace ETINs
NPI: Information and guidance

- [www.cms.hhs.gov/hipaa/hipaa2](http://www.cms.hhs.gov/hipaa/hipaa2)
  - Analysis of public comments on NPRM
  - Link to Final Rule
  - Overview of Final Rule
  - Frequently Asked Questions
  - Check-digit algorithm

- Continuing CMS guidance and outreach activities

- Upcoming WEDI Pag on NPI Implementation
Claims Attachments

- New transaction – required by HIPAA
- Not widely automated today
- Will allow health plans to request and providers to send “extra” information needed to adjudicate a claim
- Bridge between administrative (HIPAA, up to now) and clinical records
- Expect NPRM later this year
- Upcoming WEDI/AFEHCT Vendor forum
National Plan ID

- Similar concept to NPI
- Allows for unique identification of health plans
- Will simplify COB for plans and clearinghouses
- Expect NPRM later this year
What Should You Be Doing?

- Be compliant – follow the HIPAA rules
- Keep aware of future HIPAA standards rules
- Participate in industry organizations – make your voice heard
These standards and efforts will only work for you if you make your business needs known.

Keep your eye on the future.
Consolidated Health Informatics

“CHI”
History and Goals of CHI

-One of the 24 Quicksilver eGovernment Initiatives...

- To enable the sharing of health information in a secure environment to improve health
- To establish Federal health information interoperability standards as the basis for electronic health data transfer in all activities and projects and among all Federal agencies.
- Lead and influence in sync with industry
Managing Partner

HHS

Federal Enterprise-wide Governance Structure: CHI Council

Lead Partners
VA, DOD, HHS

Supporting Partners
SSA, EPA, Commerce/NIST, NASA, Justice & more...
Standards Adoption Process

**Deploy Teams**
- Form SME teams
- Define scope
- Identify candidate terminologies

**Analysis and Feedback**
- Coordinate outreach
- Evaluate terminologies
- Assess deployment

**Council Consensus**
- Technical presentation to CHI Council
- Department/agency review and feedback
- CHI Council establishes consensus

**Standards Adoption**
- Government-wide policy rollout
- Agency/department-specific implementation via architecture

Preliminary Reports To NCVHS
Final Reports To NCVHS
Range of Possible Recommendations

- Perfect terminology; needs only “evergreening” to maintain
- Imperfect terminology; must define weaknesses and actions needed to fix
- No solution at this time – recommend development of a solution – with whom would the government work to develop that vocabulary?
Announced March 2003

1. LOINC®: Laboratory Result Names
2. HL7® Messaging Standards: Includes scheduling, medical record/image management, patient administration, observation reporting, financial management, patient care
3. NCPDP: Includes retail pharmacy transactions
4. IEEE 1073 Messaging Standards: Connectivity
5. DICOM® Messaging Standards: Includes Image Information to Workstations
Announced May 2004

SNOMED CT® recommended for:
- Interventions and Procedures: Non-Lab
- Laboratory Result Contents
- Anatomy (also recommending NCI Thesaurus)
- Diagnosis/Problem Lists
- Nursing
Announced May 2004

HL7® recommended for:
- Demographics
- Units
- Immunizations
- Clinical Encounters
- Text-Based Reports (HL7® – Clinical Document Architecture)
Announced May 2004

- Interventions/Procedures: Lab - LOINC®
- Payment - HIPAA Transactions and Code Sets
- Genes and Proteins - Human Genome Nomenclature (HUGN)
- Chemicals - EPA-s Substance Registry System
Announced May 2004

Medications - Federal Drug Terminologies

- Active Ingredient – FDA Ingredient & Unique Ingredient Identifier (UNII) codes
- Clinical Drug – Rx Norm
- Manufactured Dosage Form – FDA Standards manual
- Drug Product – FDA’s National Drug Codes (NDC)
- Medication Package – FDA
- Label Section Headers – LOINC® Clinical Structured Product Labeling (SPL)
- Special Populations – HL7 Gender, Race & Ethnicity codes
- Drug Classifications – National Drug File Reference Terminology (NDF-RT) for specific uses
No Standards Identified For

- Physiology (Part B of Anatomy)
- Medical Devices and Supplies
- History and Physical
- Disability
- Multimedia
- Population Health
Implementation of Standards

- For new federal systems
- For major upgrades to systems
- Not an immediate implementation
CHI Web Site

- [http://www.whitehouse.gov/omb/egov/gtob/health_informatics.htm](http://www.whitehouse.gov/omb/egov/gtob/health_informatics.htm)